

# for PRIMARY CARE TEAMS

This TeamSTEPPS module may undergo refinements while it is being tested in primary care practices as part of a project that runs through 2015. These files are offered as a courtesy to medical offices that wish to apply TeamSTEPPS principles in their practice settings.



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#### INTRODUCTION





60 minutes



#### **MATERIALS:**

- Flipchart and markers
- Video of Primary Care Office-Based Team performing poorly
- Copies of handouts

# **(iii)** INSTRUCTOR NOTE:

The page number at the bottom of each page in the Instructor Guide directly corresponds to the slide number in the Curriculum Slides.

#### SAY:

With over a decade of safety-driven collaboration, the Agency for Healthcare Research and Quality and the Department of Defense strive to optimize the lessons learned from multiple initiatives focused on reducing errors in medicine. One such evidence-based, collaborative work is TeamSTEPPS®. Composed of structure and process, health care teams work to plan, problem solve, communicate, collaborate, and coordinate to co-create and carry out care with their patients over time, despite uncertainties and amidst any number of alternately pulsing variables. The focused, purpose-driven ability of CRM-based teaming behaviors to affect the good outcomes achieved by high-performing teams is well known. (CRM refers to crew resource management, which originated in the aviation industry.)

A name, a concept, and a methodology, TeamSTEPPS stands for Team <u>S</u>trategies and <u>T</u>ools to <u>E</u>nhance <u>P</u>erformance and <u>P</u>atient Safety.

As a concept, TeamSTEPPS focuses on strengthening the specific knowledge, skills, and attitudes of teamness critical to highly reliable team performance and outcomes

As a methodology, TeamSTEPPS conveys to participants the knowledge, skills, tools, and strategies found through decades of research critical to creating and maintaining high-performing teams. TeamSTEPPS curriculum provides the knowledge and critical success factors necessary to achieve excellence in behavioral training and performance simulation, human factors, and cultural change concepts specific to improvements in quality and patient safety.

Adaptable to all environments, TeamSTEPPS can be tailored to meet the needs of any team in any setting.

TeamSTEPPS for Primary Care Teams tailors to the primary care office-based setting, the evidence- base and many lessons learned from teaming in combat casualty care, as well as inpatient, outpatient, ambulatory, and clinic settings.

#### INTRODUCTION

#### SAY:

More than 40 years of research and evidence have been accumulated on teams and team performance in diverse areas (e.g., aviation, the military, nuclear power, health care, business and industry). TeamSTEPPS has evolved from research in these high-risk fields, where the consequences of error are great, to the health care field, a high-risk, high-stakes environment in which poor performance can lead to serious consequences or death. In effective teams, mistakes are caught, addressed, and resolved before they compromise patient safety. TeamSTEPPS provides specific tools and strategies for improving communication and teamwork, reducing chance of error, and enhancing patient safety.

Based on research, we know that teamwork is defined by a set of interrelated knowledge, skills, and abilities (KSAs) that facilitate coordinated, adaptive performance in support of one's teammates, objectives, and mission. Effective teamwork depends on each team member being able to:

- Anticipate the needs of others;
- Adjust to each other's actions and to the changing environment; and
- Have a shared understanding of how a procedure should happen in order to identify when errors occur and how to correct for these errors.

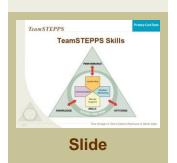
Team-related knowledge results in a shared mental model; attitudes result in mutual trust and team orientation. Outcomes of a high-performing team are adaptability, accuracy, productivity, efficiency, and safety.

# **O** INSTRUCTOR NOTE:

Before moving on to the next slide, ask if anyone has questions or comments. This is a good time to ask them to share comments they have about their own office-based teams and the challenges their teams face related to information exchange, communication, and teamwork.



#### **OVERVIEW OF TeamSTEPPS**



#### SAY:

TeamSTEPPS is an evidence-based framework to optimize team performance across the health care delivery system. This framework is composed of four teachable-learnable skills:

- Leadership
- Situation monitoring
- Mutual support
- Communication

The red arrows on the graphic of the TeamSTEPPS framework depict a two-way dynamic interplay between the four skill areas and team-related outcomes. Interaction between the outcomes and skills is the basis of a team striving to deliver safe, quality care.

Encircling the four skills is the patient care team, which represents not only the patient, but also those who play a supportive role within the health care delivery system.

More than a logo, this graphic is designed and has become associated with the conceptual model of teaming in health care.

#### **EVIDENCE FOR TEAMWORK: CLINICAL OUTCOMES**

#### SAY:

Research has found that teamwork plays a critical role in providing quality health care and that there are significant positive results when organizations implement teamwork initiatives. As TeamSTEPPS spreads across the many health care settings, the evidence base grows as well.

Some of the current clinical outcomes of team training include the following:

- 50 percent reduction in adverse outcomes, based on the averaged scores after they were weighted for severity (Mann, et al., 2006);
- 50 percent decrease in the Severity index, which measures the average severity of each delivery with an adverse event (Mann, Marcus, & Sachs, 2006);
- Reduced rate of adverse drug events; and
- Improved medication reconciliation at patient admission (Haig, Sutton, & Whittington, 2006).

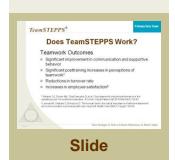
Mann S, Pratt S, Gluck P, et. al. Assessing quality in obstetrical care: development of standardized measures. Jt Comm J Qual Patient Saf 2006 Sep;32:497-505.

Mann S, Marcus R, Sachs B. Lessons from the cockpit: how team training can reduce errors on L&D. Contemp OB/GYN 2006 Jan:34-45.

Haig KM, Sutton S, Whittington J. SBAR: a shared mental model for improving communication between clinicians. Jt Comm J Qual Patient Saf 2006 Mar;32:167-75.



#### **EVIDENCE FOR TEAMWORK: TEAM OUTCOMES**



#### SAY:

Research also cites outcomes of team training related to the way the team operates, such as the following:

- Significant improvement in communication and supportive behavior;
- Significantly increased perceptions of teamwork after training (Weaver, et al., 2010);
- Reductions in turnover rate; and
- Increases in employee satisfaction (Leonard, Graham, & Bonacum, 2004).

Later on we will look at some research that demonstrates the importance of teamwork in the primary health care setting.

Weaver, SJ, Rosen MA, DiazGranados D, et al. Does teamwork improve performance in the operating room? A multilevel evaluation. Jt Comm J Qual Patient Saf 2010 Mar;36(3):133-42.

Leonard M, Graham S, Bonacum D. The human factor: The critical importance of effective teamwork and communication in providing safe care. Qual Saf Health Care 2004;13 Suppl 1:85-90.

#### PRIMARY CARE ENVIRONMENT

#### SAY:

This picture represents a moment in the life of the primary care office-based team. What the patient sees and what you see are significantly different. The general public experiences the primary care office from the perspective of one patient at a time, while primary care office-based team members know the reality of juggling numerous patients over a long period of time. The work of a primary care office-based team does not follow a linear process. It involves numerous parts working independently and interdependently.

How do you think this picture compares with the "front desk" picture that the average patient has of the primary care medical office?



Provide participants with a chance to answer the question.

#### Followup questions:

- Do you think your patients have any idea how chaotic the primary care office really is? How would they know? What would they hear? ...or see?
- If you could describe the primary care medical office in one word, what would it be? If your patients could describe the PCMO in one word, what would it be?
- If someone asked you to explain what a typical day at the primary care medical office was like, what would you say? If patients described a typical visit to the PCMO, what would they say?

Prepare to discuss their answers and discuss this concept in greater detail on the next slide. If answers differ, ask "Why?"



# PRIMARY CARE ENVIRONMENT (CONTINUED)



#### SAY:

On the surface, the office environment can and should appear orderly to patients, but to health care staff trying to attend to multiple tasks in a short timeframe, it may seem chaotic. The analogy of a duck might help you understand what you see versus what the patient sees. The part of the duck that you can see—the part above the water—appears calm, but the part below the surface is chaotic with a lot of moving parts.

However, even though what the patient sees and what the team experiences are different, the actions of the primary health care team have a profound impact on patient care. Thus, when teams fail to work well together, patients do know and experience firsthand the confusion, miscommunications, and uncoordinated care that lead to mistakes and negative effects on patient outcomes such as safety, satisfaction, or lack of engagement and activation.

It is important, therefore, that teams engage teamwork using proper teamwork strategies and skills. It is important to determine whether we are currently functioning as a real team. Next, we're going to participate in an activity that will require us to work closely as a team.

#### **TEAM-BUILDING EXERCISE**

**SAY:** Before we get started, you're going to team up with the other people at your table and complete a team-building activity.

DO: Demonstrate how to make the chains as you explain:

**SAY:** Do you remember making paper chains as a youngster or with your children? That is what we are going to do. This is a timed event with the goal to see which team can construct the longest chain. Here are the ground rules:

To make the chains, cut the construction paper into strips, make links by taping together the ends of a strip, then loop the next strip through it. Continue this process to make a chain.

You have 30 seconds to discuss with your team and 2 minutes to create the longest chain. Go.

After 1/2 minute, prompt the teams to begin building. Stop them after the 2 minute construction time. Have each group display the length of its chain. Have the groups set the first chains aside.

Now, discard all strips or unused links.

You're going to make a new chain; however, this time without the use of your dominant hand; place your dominant hand behind your back. You have 2 minutes.—Go!

After 2 minutes, have participants display the length of their second chains. Have the groups set the chains aside.

Now, you have one more chance to make the longest chain. However, this time, in addition to your dominant hand behind your back, you must not speak. You have 2 minutes., Go!-

After the 2 minutes are up, display the final chains, and debrief the exercise.

Now **debrief** with the team. Ask questions such as the following: How did you work together? What worked well? What was most challenging? What did you learn about yourself? What did you learn about your team?

# **(iii)** INSTRUCTOR NOTE:

You may use a different team-building exercise here, if you prefer.





10 minutes



- Flipchart or whiteboard
- Construction paper
- Tape
- Scissors



#### TEAMWORK IN THE PRIMARY CARE OFFICE



#### SAY:

There is a growing body of research that supports the value of teamwork in primary health care. This research indicates that teamwork results in better continuity of patient care, better access to care, and greater patient satisfaction (Stevenson, et al., 2001).

Where there is teamwork among health care providers, patients perceive that they are receiving higher quality health care (Campbell et al., 2001).

A 2003 study (Bower, et al.) found that teamwork resulted in superior care for diabetes patients.

Stevenson K, Baker R, Farooqi A, et al. Features of primary health care teams associated with successful quality improvement of diabetes care. Fam Pract 2001;18:21-26.

Campbell SM, Hann M, Hacker J, et al. Identifying predictors of high-quality care in English general practice: observational study. BMJ 2001;323:1-6.

Bower P, Campbell S, Bojke C, et al. Team structure, team climate, and the quality of care in primary care: an observational study. Qual Saf Health Care 2003;12:273-9.

#### PRIMARY CARE OFFICE-BASED TEAM STRUCTURE

#### SAY: Is PCMO structured for success?

Each primary care office-based team is made up of team members from various categories:

- · Clinicians and clinical support staff
- Administrative team members
- Ancillary service members

Clinicians are those individuals such as the MD's, DO's, physician's assistants, and nurse practitioners who are directly accountable for the medical services, consultation, and hands-on delivery of care to the patient. The clinical support staff consists of medical assistants, nurses, including RNs and LPNs, and others who provide assistance to the clinician in the delivery of medical services.

The administrative team is made up of receptionists, office managers, billing associates, and those personnel who facilitate the day-to-day operations of the medical office. Finally, the ancillary and support staff includes all services that facilitate patient care and may or may not be located where patients receive their routine care.

Ancillary Services are primarily a service delivery team whose mission is to support the Core Team. In general, an Ancillary Services Team functions independently, such as laboratory services, pharmacy services, and radiology.

Support Services are primarily a service-focused team, such as housekeeping and building maintenance, whose mission is to create efficient, safe, comfortable, and clean health care environments, which affect the patient care team, market perception, operational efficiency, and patient safety.

One thing to keep in mind is that the patient is always at the center of the primary care office-based team. It's the patient around whom the medical practice revolves. Team members must always remember care is a patient-provider partnership where patients contribute to and co-create their plans of care.

This slide illustrates the interdependence of the various staff within the primary care office-based team: They must collaborate, communicate, and coordinate actions to engage and activate the patients to participate in and manage their care.



Slide

#### LET'S TALK ABOUT YOUR TEAM



#### SAY:

I now want you to think about your own team. Particularly, who fills the roles we talked about on the previous slide? How, and where, do these individuals interact and exchange information? Please take the next few minutes to answer the questions on the handout titled *Thinking About Your Primary Care Office-Based Team* and we'll discuss your responses when everyone's done.

# **O** INSTRUCTOR NOTE:

Refer participants to the handout titled *Thinking About Your Primary Care Office-Based Team*. After 2 or 3 minutes, sample responses from the group(s).

# OBSTACLES PRIMARY CARE OFFICE-BASED TEAMS FACE

#### **TeamSTEPPS**

#### SAY:

Teamwork can be hindered by various interpersonal or workrelated obstacles that arise in the work environment. Identifying these obstacles will help teams choose effective tools and strategies to optimize teamwork and overcome these identified barriers to optimal care in the primary care medical office setting.

This slide provides examples of challenges faced by the primary care office-based team. Obstacles can include conflict among team members, lack of coordination, distraction, fatigue, roles not clearly defined, miscommunication, and ineffective or incomplete sharing of information.

#### Share the following examples:

Lack of coordination—An employee calls in sick and there is no replacement available. The person's duties are split up among two other employees, but the supervisor does not tell them what duties they are each responsible for and they do not clarify between themselves, so some important work is left undone.

Workload—Same scenario as in "lack of coordination" but in this case there is simply too much work, resulting in an inability or failure to properly prioritize and coordinate, and important work is left undone.

Miscommunication—The receptionist takes a phone message, but records the phone number incorrectly. The patient goes to urgent care because she is not called back.

# **O** INSTRUCTOR NOTE:

Ask participants if they can suggest other obstacles to patient care resulting from ineffective teamwork.



# WATCH A PRIMARY CARE OFFICE-BASED TEAM IN **ACTION**



#### Slide

#### SAY:

Let's watch four different primary care teams in action. Pay special attention to see if they are maximizing teamwork. Before we start the film, pull out your handout titled "Video Reflections."

While watching the video, record any thoughts you may have on the handout and we will discuss them after the video.



**DO:** Play the video by clicking the director icon on the slide.



## **DISCUSSION:**



Discuss the video and what went wrong. Ask participants what could have been done to improve this situation.

## Possible discussion points:



- Primary Care Office-Based Team video
- What did the team do wrong in this video?
- How could the situation have been handled better?
- Are these situations that you could potentially see happening in your clinic?



#### **FEEDBACK ON VIDEO**

# **(1)** INSTRUCTOR NOTE:

At the end of the video, ask for comments—in particular, ask participants to identify breakdowns in teamwork they observed. Show PPT slide 14, and on a flipchart, mark the four categories of

- · Leadership.
- · Communication.
- Situation monitoring.
- · Mutual support.

For each participant comment, ask the group in which category they think it belongs. You can record their comments on the flipchart under the appropriate category.

# INSTRUCTOR NOTE:

This serves as a good point at which to take a break. Allow participants to get up, move around, and break for an allotted time.



# **TEAM PROCESS, TOOLS, AND STRATEGIES**



#### SAY:

The rest of the training will be spent exploring specific process, tools, and strategies that have been proven effective for promoting highly reliable team outcomes by addressing the types of breakdowns that we viewed in the video. Specifically, we will explore how proficiency in each teamwork skill can affect performance in the primacy care setting.

Each strategy falls under one of the four critical and evidencebased teamwork skills around which TeamSTEPPS is designed:

- 1. Leadership
- 2. Situation Monitoring
- 3. Mutual Support
- 4. Communication

Let's begin by discussing Leadership.

#### **LEADERSHIP**

#### SAY:

Leadership is a critical component of effective team performance and the first component of TeamSTEPPS that we will consider. Traditional definitions of leadership center on the concept of influence. For example, Peter Northouse (2006) refers to leadership as a process whereby an individual organizes and influences a group of individuals to achieve a common goal. Leaders influence team effectiveness by:

- Facilitating team actions;
- Ensuring that teams have the necessary resources for optimal performance;
- Ensuring that roles and tasks are understood by all team members; and
- Being knowledgeable of team members' skills and expertise in order to properly allocate tasks and material resources.

Within the clinical team, the primary leadership role generally is held by the primary care provider. However, each clinical team member must know each other's role, including strengths and weaknesses and areas of subject matter expertise.

In the operations team, a second leadership role may be that of administrative personnel whose tasks include managing medical records, coordinating transfer of patient information, and interfacing with patients on non-medical issues.

Traditional definitions of leadership have given rise to the concept of **shared leadership—**a partnership where two or more people or a team of people share power and join forces to move toward the accomplishment of a shared goal (Moxley, 2000). Leaders "impact team effectiveness **not** by handing down solutions…, but rather by facilitating [team] problem-solving" (Salas, et al., 2004).

Among the characteristics of effective leaders are (1) Role modeling and shaping of teamwork through open sharing of information; (2) providing constructive and timely feedback; and (3) facilitating briefs, huddles, and debriefs and resolving conflicts.

Northouse PG. Leadership: theory and practice. 4th ed. Thousand Oaks, CA: Sage; 2006.

Moxley RS. Leadership and spirit. San Francisco: Jossey-Bass; 2000. Salas E, Burke CS, Stagl KC. Developing teams and team leaders: strategies and principles. In: Demaree RG, Zaccaro SJ, Halpin SM. Leader development for transforming organizations. Mahwah, NJ: Lawrence Erlbaum Associates; 2004.



#### LEADERSHIP STRATEGIES



#### SAY:

High-performing team leaders ensure teams engage three critical events—to plan, problem solve, and improve over time.

**Briefs** are held for planning purposes; **huddles** are used for problem solving; and **debriefs** are used for reflection and process improvement. We will now explore each of these in greater detail. As we go forward, keep in mind that although the team leader typically facilitates team events, **any team member** can request a brief, huddle, or debrief at any time, as the need arises. This is an example of shared leadership.

#### **BRIEFS**

#### SAY:

Briefs, sometimes referred to as team meetings, are held for planning purposes. The designated leader is responsible for organizing a 3-5 minute brief to discuss essential team information. All team members are expected to attend. The following information should be discussed in a brief:

- Team membership and roles—who is on the team and who
  is the designated team leader.
- Clinical status of the team's patients—the current condition, diagnosis, plan, and status of each patient assigned to the team.
- Team goals, pitfalls, and barriers—what is to be accomplished and who is to do it.
- Issues affecting team operations—resources normally available that may be restricted during that particular day.

Successful teams measure their effectiveness in terms of goal achievement. Performance goals typically are set during the team brief. With the team leader facilitating the process, team members actively participate to establish both clinical and team work goals.

Where and when does this planning occur for you now?

Who attends? Clinical or Ops or both?

Who should attend?



#### **BRIEFING CHECKLIST**



#### SAY:

A briefing checklist is similar to the preflight checklist used in aviation. Team leaders should cover the items on the checklist. In aviation, preflight briefings provide the ideal forum for building a team dynamic that allows everyone to work together when carrying out routine tasks and when tackling unexpected problems. Briefs:

- Clarify who will be leading the team so that others know to whom to look for guidance;
- Open lines of communication among team members, ensuring that they all can contribute their unique knowledge base to the task, and thereby set the tone for the upcoming slate of patients or, in some settings, the upcoming clinic session. Protocols, responsibilities, and expected behaviors are discussed and reinforced so that possible misunderstandings are avoided;
- Prepare the team for the flow of the day's patients, contingency plans, and means for resolving any unusual circumstances; and
- By specifying expectations, increase understanding of what is expected, help prioritize what to do, and reduce chances of getting distracted or forgetting a task altogether.

Have you ever participated in a brief? For those who have, were the items on the checklist used or, if not, what was missing? What would you add to the briefing checklist?

#### **HUDDLE**

#### SAY:

A huddle is a quick, reactive, "touch base" meeting tool to help team members regain situation awareness. It is used to reinforce plans that are already in place for treating patients and to assess the need to revise plans. It quickly allows team members to discuss critical issues and emerging events, anticipate outcomes and likely contingencies, assign resources, and express concerns. It is a tool for developing shared understanding between team members regarding the plan of care. Huddles provide team leaders with an opportunity to informally monitor patient and team-level situations. The difference between a brief and a huddle is that, with a brief, the leader knows and shares the plan; with a huddle, the leader changes the plan.

Because information changes over time, the huddle is an important tool for monitoring and updating the team. A sudden increase in the activity level of an individual or of the team signals the need to reevaluate workload status, and workload distribution may need to be adjusted.

Let's take a few minutes to brainstorm some examples of times when a huddle would be appropriate. These examples could be from your actual experience in the medical office or experiences that you imagine could happen. Use the handout titled *When and Why To Use a Huddle* to list a few possible examples.

# **O** INSTRUCTOR NOTE:

Sample some responses, and then emphasize that updates should occur as often as necessary, and particularly whenever information changes and needs to be shared.

#### SAY:

A common example of when a team would use a huddle is if a team member has called in sick or isn't able to make it to work. The team strategy for the day then has to be revised. It should not be assumed that everything will be taken care of. Instead, form a huddle and address the ramifications of this team member being out for the day and how the team will make up for his or her absence.

Discuss a common scenario in which the PCMO team huddles to discuss new data or changes to the plan.



#### **DEBRIEF**



#### SAY:

The debrief is a short, informal information exchange used as a process improvement tool. It occurs after an event or shift and is designed to improve teamwork skills. Team actions and outcomes are discussed against the established plan: We had a plan—did we achieve that plan? Debriefs are most effective when conducted in an environment where all actions are viewed as learning opportunities. Debriefs can include any of the following:

- Accurate recounting and documentation of key events;
- Analysis of what occurred, what worked, and what did not;
- Reflection on "why" and implications for practice;
- Discussion of lessons learned and how the team will alter the plan next time;
- Establishment of a method to formally change the existing plan to incorporate lessons learned; and
- Recognition of good team contributions and catches.

Debriefs should be the subject of a short (about 3 minutes or less) team event typically initiated and facilitated by the team leader. Debriefs are most useful when they relate to specific team goals or address particular issues related to recent team actions. Debriefs also maintain effectiveness by not assigning blame or failure to an individual.

Although the debrief is meant to be a process improvement tool, it may be necessary at times to conduct a complete process review and system redesign, particularly if the same issues or events continue to recur. Such recurring issues may be identified during a debrief and can then be mapped out and accessed at a designated time in the near future.

#### **DEBRIEF CHECKLIST**

#### SAY:

The debrief checklist is useful during a debrief to ensure that all information is discussed relative to the plan established in the team brief. To conduct a debrief, the team leader recaps the established plan and key events that occurred and asks questions related to team performance, for example, *Did everything happen for a patient or patients that was intended? Were patient followup needs clarified? What events led up to \_\_\_\_\_\_?* 

The team should assess how each of the following plays a role in the team's performance: team leadership, situation awareness, mutual support, and communication. The team leader should then ask, What are our take-aways or lessons learned from this experience? The team then should set goals for improvement.

The checklist on the slide is just an example but could serve as a real life checklist.



#### LEADERSHIP VIDEO



Slide





Video

#### SAY:

Let's watch the first primary care team demonstrate team leadership, but this time let's watch them demonstrate proper leadership.



**DO:** Play the video by clicking the director icon on the slide.



Discuss the video and compare it to the first scenario in the first video. What went better this time? How did the team leader improve the situation?

Possible discussion points:

- How was leadership demonstrated in this video?
- Was this strategy effective? Why was it/was it not effective?
- Did you see any other opportunities for leadership to be demonstrated in this video?
- Have you encountered situations similar to this with your team?



Exercise

■ Think about your office team.

#### LEADERSHIP EXERCISE

#### SAY:

Take a few minutes to think about your own office teams in terms of leadership and whether you have encountered leadership problems: the *what*, not the *who*.

# Have you encountered a leadership problem? What strategy would you use to ove

#### Slide

# INSTRUCTOR NOTE:

After a minute or two:

- Ask them to explain their example(s) and suggest an appropriate strategy (brief, huddle, debrief) to address and overcome the problem.
- Allow them about 5 minutes to group with two or three other participants and share their experiences.
- Then ask if there are any volunteers who are willing to share their experience(s) as well as their suggestion for a strategy that can be used to address this issue.



#### FRONT OFFICE SCENARIO

#### SAY:

Now let's look at the following scenario and see how leadership can be demonstrated in the nonclinical aspects of the primary care team.

#### **READ THE SCENARIO:**

Your patient is an elderly man who just had cataract surgery and cannot drive. He was taken to the clinic by his son for a followup on his blood pressure and diabetes. While he was in the examination room, his son was called away on an emergency. When the patient finished his appointment and found that his son was not waiting for him, he was very upset. The front desk administrative person realized that the patient had no way to get home and called a quick huddle with the nurse and the billing specialist. Together they decided to arrange for a taxi to transport the patient to his home. The front desk administrator then called the patient after he arrived home to make sure all was well.

The outcome in this scenario is only one of many possible outcomes. Can you think of any other way this situation could have been resolved?

As you can see from this scenario, the strategies taught in TeamSTEPPS apply to everyone within the primary care office. Leadership is the responsibility of everyone on the team.



#### **LEADERSHIP TOOLS**



#### SAY:

Earlier we discussed the barriers to delivering high-quality, safe care in the PCMO setting. Team briefs, huddles, and debriefs serve to mitigate the barriers to achieving the excellent performance and outcomes desired. Excellent leaders partner with their patients and clinical and operational care team members to take the critical actions necessary to keep the team tasks and care tailored and on track for obtaining safe, high-quality outcomes.

This is a summary of what this training has covered under leadership. Researchers (Fleishman, et al., 1991) have identified skills such as planning, organizing, problem-solving, facilitating, and supporting the team action process as key behaviors that leaders need to take to ensure that their teams perform effectively and attain their desired outcomes.

Morgeson (1997) later expanded on this and grouped key leadership skills into three categories: monitoring of team and environmental cues, diagnosis of issues—using information to make decisions and develop action plans, and intervention.

DeChurch and Marks (2003) further refined the skills as two key leader behaviors that have a vital impact on team performance: delegating tasks and supplying information to team members. Leaders must support their teams by communicating with them and holding information sessions to reinforce the coordinated actions to be taken.

Teams with leaders who performed these behaviors reported significantly greater sharedness in mental models, committed fewer errors in flight, and performed better than teams with leaders who did not perform these behaviors.

# INSTRUCTOR NOTE:

This ends the *Leadership* module and may be a good place to break again. The next module will begin the discussion on *Situation Monitoring*.

Fleishman EA, Mumford MD, Zaccaro SJ, et al. Taxonomic efforts in the description of leader behavior: a synthesis and functional interpretation. Leadership Q 1991;2:245.

Morgeson FP. Leading as event management: toward a new conception of team leadership. Poster session presented at meeting of the Society of Industrial and Organizational Psychology, St. Louis, MO, 1997. DeChurch LA,.Marks MA. Leadership in multiteam systems. J Appl Psychol 2006 Mar;91(2):311-29.

#### SITUATION MONITORING

#### SAY:

We will now consider the second component of TeamSTEPPS. Situation monitoring is defined as the process of actively scanning behaviors and actions to assess elements of the situation or environment. Situation monitoring is a skill that individual team members can acquire, practice, and improve on. It enables team members to identify the potential issues or minor deviations early enough so that they can correct and handle them before they become a problem or pose harm to the patient.

The benefits of situation monitoring are that it fosters mutual respect and team accountability, and through the process of cross-monitoring provides a safety net for both the patient and the team.

Examples of situation monitoring include assessing the patient's condition, noting malfunctioning equipment, and being aware of workload spikes and stress levels among team members.

Finally, remember that you should engage the patient whenever possible.

# **O** INSTRUCTOR NOTE:

Ask participants to describe some of the ways they monitor the situation in their medical offices.



#### **CROSS-MONITORING**



#### SAY:

Cross-monitoring is a process of ongoing monitoring of the care environment to recognize risk or unfolding error and to interrupt or correct an action or event before the patient is harmed or injured.

Commonly referred to as "watching each other's back," crossmonitoring involves monitoring all actions against the established plan and advocating or asserting a position or corrective action when the plan and actions differ or when risk is perceived as escalating and task assistance is required.

Cross-monitoring actions include providing feedback and keeping track of fellow team members' behaviors to ensure that procedures are being performed appropriately. Cross-monitoring is an act of patient and caregiver advocacy and allows team members to check and correct their actions, if necessary.

Cross-monitoring is not a way to "spy" on other team members but a way to provide a safety net or error prevention/error interruption mechanism for the team, ensuring that mistakes or oversights are caught early. When all members of the team trust the intentions of their fellow team members, a strong sense of team orientation and a high degree of psychological safety result.

# INSTRUCTOR NOTE:

Refer to the handout titled *Cross-Monitoring*. Ask participants to form pairs and share an example of a situation in which cross-monitoring was successful and one in which cross-monitoring should have been used but was not. After about 5 minutes, ask for a few pairs to volunteer to share their examples with the larger group.

#### **STEP**

#### SAY:

How can team members acquire a trained eye as they "monitor the situation"? What components of the situation provide clues about impending complications or contingencies? The STEP process is a mnemonic tool that can help team members monitor the situation and the overall environment. The STEP process involves ongoing monitoring of the following:

**S**tatus of the patient—Ask, What is the patient's status? Vital signs? Medications? Stress level?

Team members—Ask, What are my team members doing? Workload? Fatigue level? Stress level? Skill level?

Environment—Ask, Are the exam rooms properly stocked? Are the blood pressure cuffs, otoscope, and ophthalmoscope working properly? Do we need any special equipment for a procedure today? Are there enough staff to attend to all patients?

Progress toward the goal—Ask, What is the progress toward today's goals (i.e., how is the day progressing)? Are we behind? Are patients waiting too long? Are things being left undone because of time pressure? Is the plan still appropriate or does it need to be revised?

Examples in the medical office might include the following: A patient comes in complaining about a sore throat but it turns out she may have pneumonia.

**Status of the patient:** Patient has pneumonia.

Team members: Physician isn't available or is at lunch.

Environment: Need a room with oxygen.

**Progress toward goal:** Ask nurse to come in and assess patient and administer oxygen. Find a nurse to help her with other duties.



#### SITUATION MONITORING VIDEO



#### SAY:

Let's watch the second primary care office demonstrate proper team situation monitoring.



**DO:** Play the video by clicking the director icon on the slide.



# DISCUSSION:

Discuss the video and what went better this time.

Possible discussion points:

- Was situation monitoring demonstrated in this video?
- Was this strategy effective? Why was it/was it not effective?
- Did you see any other opportunities for situation monitoring to be demonstrated in this video?
- Have you encountered similar situations with your team?
   If so, how did you overcome them?





#### **MATERIALS:**

Video



#### SITUATION MONITORING EXERCISE

#### SAY:

Think about your own office team and daily routines in terms of situation monitoring. Have you encountered barriers to proper situation monitoring or, if not, do you anticipate barriers in this new team structure?

# TransTEPPS\* Situation Monitoring Exercise If Think about your daily office routine. If Have you encountered barriers to situation monitoring? Whatstrategy would you use to overcome them?

# **O** INSTRUCTOR NOTE:

#### After a few minutes:

- Ask participants to suggest an appropriate strategy (STEP, cross-monitoring) to address and overcome the problem.
- Allow them about 5 minutes to group with two or three other participants and share their experiences.
- Then ask if there are volunteers who are willing to share their experiences as well as their suggestion for a strategy that can be used to address the issue.



#### FRONT OFFICE SCENARIO

#### SAY:

Now let's look at the following scenario and see how situation monitoring can be demonstrated in the nonclinical aspects of the primary care team.

#### **READ THE SCENARIO:**

A patient was due for a mammogram and the provider ordered it. Upon arrival at the mammography service, the patient was told that she would have to pay for the mammogram, since her insurance company did not cover it. The patient returned to the primary care clinic distraught and told the secretary that she did not have the money to pay for this. She was especially upset because her mother was a breast cancer survivor. The secretary assessed the status of the situation, the team members who needed to fix it (a billing specialist), the environment (the patient was upset), and the progress toward the goal (patient was being denied access). The secretary then informed the billing specialist, who called the insurer and clarified that the patient had not had a mammogram for 2 years (the insurer had the wrong dates) and was due. The insurer realized their error and thus covered the mammogram.

As with leadership, situation monitoring can be practiced by everyone within the primary care office. Remember, teamwork is the responsibility of everyone.



#### SITUATION MONITORING TOOLS



#### SAY:

This is a summary of what this training has covered under situation monitoring. There are now additional barriers, additional tools and strategies, and additional outcomes. Because teams are typically composed of members with distinct roles who tend to have unique information, it is important to pay attention to the factors that promote and undermine the opportunity for team members to present and discuss their diverse information and observations. The act of sharing and discussing information gained from situation monitoring provides the opportunity to gather more information about the situation and helps cultivate a mutual understanding, commonly referred to as a shared mental model. A shared mental model is an organized knowledge structure of relevant facts and relationships about a task or a situation that are commonly held by members of a team. The basic premise about the relationship between teamwork and shared mental models is that team effectiveness will improve if team members have a shared understanding of the situation. Evidence suggests that team members who possess shared mental models yield teams that:

- · Can anticipate.
- · Back up and fill in for one another.
- Communicate to ensure that team members have the necessary information for task performance.
- Understand each others' roles and how they interplay.

In health care, if the wrong plan is developed, potentially all actions that follow are wrong, and the patient and the caregiver are at risk. A shared mental model serves as an error-reduction strategy, and caregivers who understand the plan monitor all actions relative to that plan.

# INSTRUCTOR NOTE:

This is the end of the *Situation Monitoring* module and is a good place to break. The next module will begin the discussion on *Mutual Support*.

#### **MUTUAL SUPPORT**

#### SAY:

We will now consider the third component of TeamSTEPPS, **Mutual Support**. Mutual support, commonly referred to as
"backup behavior" in the teamwork literature, is the essence of
teamwork; it is critical to the social and task performance of
teams. The construct suggests some degree of task
interchangeability among members because they must fully
understand what each of the other team members does. Constant
vigilance is required of all team members to compensate for
individual differences in team performance.

Mutual support enables teams to function effectively. In a health care environment, one team member's work overload may result in fatal consequences. Mutual support provides a safety net to help prevent errors, increase effectiveness, and minimize strain caused by work overload. Over time, continuous mutual support fosters team adaptability, mutual trust, and team orientation.

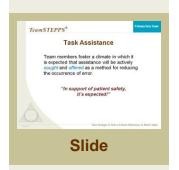
# **(1)** INSTRUCTOR NOTE:

Ask participants what types of behavior might constitute mutual support or team backup behavior? Refer them to the handout titled *Mutual Support Behaviors* and ask them to form small groups to generate a list of mutual support behaviors. Allow 5 or 6 minutes for this activity. Sample responses from the total group. Record responses on a flipchart. If any items on the following list are missing, you may offer these as additional examples of mutual support behaviors:

- Monitoring other team members' performance to anticipate assistance requests;
- Offering or requesting assistance;
- Filling in for a member who is unable to perform a task;
- Cautioning team members about potentially unsafe situations;
- Self-correcting, as well as helping others to correct mistakes;
- Distributing and assigning work thoughtfully;
- Rerouting/delaying work so that the overburdened team member can recover;
- Regularly providing feedback to each other; and
- Providing encouragement.



#### TASK ASSISTANCE



#### SAY:

Teams are at risk whenever they are over- or underloaded. The reason? They lose their situation awareness and in doing so they drop or abandon the plan.

Task assistance is defined as team members' fostering a climate of mutual support in which it is **expected** that assistance will be actively sought and offered as a way to reduce errors.

Task assistance is guided by situation monitoring because situation awareness allows team members to effectively identify the need for assistance by others on the team. Some people have been conditioned to avoid asking for help because they fear suggesting lack of knowledge or confidence; many people refuse to seek assistance when overwhelmed by tasks. In support of patient safety, however, task assistance is expected.

Task assistance may involve asking for assistance when overwhelmed or unsure; helping team members perform their tasks; shifting workload by redistributing tasks to other team members; delaying/rerouting work so the overburdened member can recover; and/or filling in for overburdened team members.

Error vulnerability is increased when people are under stress, are in high-task situations, and are fatigued. One of the most important concepts to remember about task assistance is that assistance should be actively offered and given whenever there is a concern for patient safety related to workload.

Always remember that the focus should be on patient safety rather than the individual's need for task assistance.

#### **FEEDBACK**

#### SAY:

Feedback is another type of mutual support. It is information provided to team members to improve team performance. The ability to communicate self-improvement information in a useful way is an important skill. Any team member can give feedback at any time. It is not limited to management roles or formal evaluation mechanisms.

Performance feedback benefits the team in several ways:

- It fosters improvement in work performance;
- · It meets the team's and individual's need for growth;
- · It promotes better working relationships; and
- It helps the team set goals for ongoing improvement.

Examples of giving feedback include the following:

Cautioning team members about potentially unsafe situations, such as, "The asthma patient appears to be breathing harder after the nebulizer treatment. Should I ask Dr. Smith what to do next?"

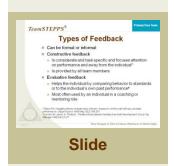
Providing necessary information, for example, "Did you know that the patient saw her cardiologist last week? There is no report in the chart; I will have her office fax over the report."

Providing encouragement, for example, the physician's praising a new clinical support person for doing a good job and remaining cool and composed under the stress of the situation.

**Note:** Feedback between the health care team, patients, and their families is discussed in the section on Communication.



### TYPES OF FEEDBACK



#### SAY:

Feedback can be provided by anyone on the team; it can be either formal or informal, and it can be constructive or evaluative.

**Formal** feedback tends to be retrospective in nature, is typically scheduled in advance and away from the clinical area, and has an evaluative quality. Examples include collaborative discussion, case conferences, and individual performance reviews.

**Informal** feedback, on the other hand, occurs in real time and on an ongoing basis; it focuses on knowledge and practice skills development. Examples include huddles and debriefs.

**Constructive** feedback is task specific, focuses attention on the performance and not on the individual, and is usually provided by all team members regardless of their roles on the team. It is most beneficial when it is focused on team processes and is provided regularly.

**Evaluative** feedback helps the individual understand performance by comparing behavior with standards or with the individual's own past performance. It is not a comparison of the individual's performance with that of other team members, and most often it is provided by individuals in a mentoring or coaching role.

Would someone like to share an example of when he or she effectively provided feedback and how the team member(s) responded? What factors do you think contributed to the team members' responses?

#### CHARACTERISTICS OF EFFECTIVE FEEDBACK

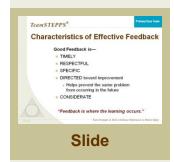
#### SAY:

Feedback is the facet of team communication in which learning occurs. Rules of effective feedback include the following—it is...

- Timely—If you wait too long, you forget facts and the feedback loses its "punch." Feedback is most effective when the behavior being discussed is fresh in the mind of the receiver.
- Respectful—Feedback should not be personal, and it should not be about personality—it should be about behavior. Never attribute a team member's poor performance to internal factors because such destructive feedback lowers self-efficacy and subsequent performance.
- Specific—Feedback should be related to a specific situation or task. Imagine that you are receiving feedback from a peer who tells you that your patient relationship skills need work. That statement is too general to use as a basis for improvement. The person receiving feedback will be better able to correct or modify performance if specific actions are mentioned during feedback.
- Directed—Goals should be set for improvement; this helps prevent the same problem from recurring in the future.
- Considerate—Be considerate of team members' feelings
  when delivering feedback, and always remember to praise
  good performance. A feedback message will seem less
  critical if you also provide information on the positive
  aspects of a person's performance as well as how the
  person may improve. Generally, fairness and respect will
  cushion the effect of any negative feedback.

Feedback may also be used to reinforce positive behaviors. We all benefit from knowing that we've done a good job and that our performance has been recognized by others. Unacceptable negative feedback includes the following:

- Delayed feedback—Feedback must be timely enough for an individual to be able to readily associate it with the behavior. Delivering feedback several weeks after poor performance has occurred is too late for it to be effective.
- Publicly delivered feedback—Negative feedback should never be expressed to individuals in front of other team members because there is the possibility that this approach will cause the individual receiving feedback to feel humiliated.



### **ADVOCACY AND ASSERTION**



#### SAY:

Advocacy and assertion interventions are invoked when a team member determines the unfolding actions differ from the expected or established plan of care. In advocating for the patient and the medical care plan, the observing team member asserts a corrective action to raise the concern and allow fellow team members to check or correct errors or the loss of situation awareness. Failure to use advocacy and assertion has been frequently identified as a primary contributor to the clinical errors found in malpractice cases and sentinel events.

You should advocate for the patient even when your point of view is unpopular, is in opposition to another person's view, or questions authority. When advocating, you should assert your point of view in a firm and respectful manner. Be persistent, be persuasive, and provide the data or evidence for your concerns.

#### THE ASSERTIVE STATEMENT

#### SAY:

Team leadership must foster an atmosphere in which the participation of every team member can flourish. This is accomplished by maintaining an environment that is predictable, but at the same time, retaining the ability to respond to changing clinical situations.

Team members must always feel their input is valued. More important, their input should be expected, especially in situations that threaten patient safety. Medical team members must respect and support the authority of the team leader while clearly asserting their suggestions or communicating concerns. These two concepts go hand in hand: respect for team members means speaking up when patient safety is at stake.

When the clinical situation dictates that the medical team member must be assertive and address concerns regarding patient care, the assertive statement is in action. It is a nonthreatening, respectful way to ensure that the concern or critical information is addressed. It is a five-step process consisting of the following:

- · Open the discussion.
- State the concern.
- State the problem—real or perceived.
- Offer a solution.
- · Obtain an agreement.

**Example:** A nurse witnesses a physician treating a receptionist rudely in front of a patient. The nurse waits until after the incident and takes the physician aside.

### **O** INSTRUCTOR NOTE:

Using the example above, ask participants how they would do each of the following:

- Open the discussion.
- State the concern.
- State the problem—real or perceived.
- Offer a solution.
- Obtain an agreement.



### **CONFLICT RESOLUTION OPTIONS**



When differences and conflicts in health care arise, they tend to be rooted in one of two reasons; either our information or our personalities differ. The tools to manage these conflicts differ as well.

Information conflict tends to be more task related; it involves differing views, ideas, and opinions. It could be a disagreement about the content of a decision.

Personal conflict stems from interpersonal compatibility and is not usually task related. Tension, annoyance, and animosity are common, and it can be argumentative.

Attempts should be made to resolve both types of conflict before they interfere with work and undermine quality and patient safety. Information conflicts left unresolved may evolve into personal conflict in the long run and severely weaken teamwork.

Disruptive behavior among staff should be actively discouraged. Organizations should develop guidelines for acceptable behavior to assist staff in better identifying, reporting, and managing behaviors that cause disruption to patient safety.

Types of disruptive behavior include condescending language or voice intonation, impatience with questions, reluctance or refusal to answer questions or telephone calls, strong verbal abuse or threatening body language, and physical abuse.

## INSTRUCTOR NOTE:

**For more resources:** The TeamSTEPPS Professional Conduct ToolKit developed for the Department of Defense (DoD) is available to assist teams with proper team deportment and development. Course information can be found on the DoD Patient Safety Learning Center Web site:

www.health.mil/dodpatientsafety/ProductsandServices/PSLC.aspx

#### TWO-CHALLENGE RULE

#### SAY:

The Two-Challenge Rule is the tool developed to manage conflict when our information differs.

The tool was developed by human factor experts to help airline captains prevent disasters caused when otherwise excellent decisionmakers experience momentary lapses in judgment. In the clinical environment, team members should challenge colleagues if requesting clarification, and confirmation does not alleviate the concern regarding potential harm to a patient.

It is important that the challenger voice his/her concern by advocating and asserting his/her statement by restating it, and if the initial assertion is ignored, by rephrasing (thus, the term "Two-Challenge rule"). These two attempts may come from the same person or from two different team members. The first challenge should be in the form of a question, and the second should provide some support for the concern.

Always remember that this is about advocating for the patient. This two-challenge tactic ensures that an expressed concern is heard, understood, and acknowledged.



### TWO-CHALLENGE RULE (CONTINUED)



#### SAY:

This slide illustrates the two challenges. If, after two attempts, the concern is still disregarded, but the team member believes patient or staff safety is or may be severely compromised, the Two-Challenge Rule mandates taking a stronger line of action or using a supervisor or chain of command. This overcomes the natural tendency to believe that the medical team leader must always know what he or she is doing, even when the actions taken depart from established guidelines.

When invoking this rule and moving up the chain, it is essential to communicate to the entire medical team that additional input has been solicited.

It is also important to remember that if you personally are challenged by a team member or patient or family member, it is your responsibility to acknowledge the concerns instead of ignoring the person who brought the concern to you.

Finally, any team member should be empowered to "stop the line" if he/she senses or discovers an essential safety breach. This is an action that should never be taken lightly; it requires immediate cessation of the process to resolve the safety issue.

Are team members able to stop the line now?

How do you know?

Are patients and families able to stop the line now?

How do you know?

#### **CUS WORDS**



#### SAY:

The CUS technique provides another framework for conflict resolution, advocacy, and mutual support. There are signal words common in the medical arena, such as "danger," "warning," and "caution." These words catch the reader's attention.

CUS and several other signal phrases have a similar effect in verbal communication. When they are spoken, all team members will understand clearly not only the issue but also the magnitude of the issue.

CUS stands for the following actions:

- First, state your concern.
- Next, state why you are uncomfortable.
- Then, if the conflict is not resolved, state that there is a safety issue. Describe in what way the concern is related to safety. If the safety issue is not acknowledged, a supervisor should be notified.

Other phrases that have a similar effect are, "I would like some clarity about..." and "Would you like some assistance?"

#### **DESC SCRIPT**

#### SAY:

The tool for managing conflict when our personalities differ is the DESC script. This is a constructive approach for communicating effectively and for managing and resolving all types of conflict, but particularly conflict that has become personal in nature. The DESC script is used in conflict scenarios in which behaviors aren't practiced, when hostile or harassing behaviors are ongoing, and when safe patient care is in jeopardy.

DESC is a mnemonic for the following actions:

- D = **Describe** the specific situation;
- E = **Express** your concerns about the action;
- S = **Suggest** other alternatives; and
- C = State the **consequences**.

Ultimately, consensus should be reached.



#### **DESC-IT**



#### SAY:

When you initiate and use the DESC script, you need to ensure that the following crucial actions are taken:

- Ensure that the discussion is timely;
- Work on win-win—Despite the interpersonal conflict with the other party, team unity and quality of care depend on coming to a solution that all parties can live with;
- Frame problems in terms of personal experience and lessons learned:
- Choose the location—a private location that is not in front
  of the patient or other team members will allow both parties
  to focus on resolving the conflict rather than on saving face;
- Use "I" statements rather than blaming statements, e.g.,
   "When you do \_\_\_\_\_, I feel \_\_\_\_\_";
- · Keep in mind that critique is not criticism; and
- · Focus on what is right, not on who is right.

#### **CONFLICT RESOLUTION**

#### SAY:

There are commonly used methods to resolve conflict, but these do not result in the best outcome. They include the following:

Compromise—With this method, both parties settle for less.

**Avoidance**—With this method, issues are temporarily ignored or sidestepped. This can be worse than compromise because people's feelings become bottled up and will eventually seep out somehow. This makes avoidance a poor option for ensuring that safety and patient care are put first.

**Accommodation**—With this method, the focus is on preserving relationships. This is not a good option because the focus should be on safety and patient care.

**Dominance**—With this method, conflicts are managed through directives for change. This option is authoritative and does not promote a culture of communication and support.



#### COLLABORATION



#### SAY:

Collaboration is defined as working together to resolve a conflict to achieve a mutually satisfying solution that results in the best outcome. Unlike compromise, where someone wins and someone loses, collaboration is the integration of the best of both sides (Katzenbach and Smith, 1993). This is the best way to address conflict because collaboration has the highest potential for a winwin situation for all parties—that is, for all team members, for the patient care team, and for the patient.

Collaboration involves a commitment to a common mission, which is the safe and improved care of the patient. Collaboration is a **process**, not an event. It takes time and effort, and it is not always feasible, particularly in critical situations when time is of the essence. In such cases, the issue can be included at staff meetings, and ways to handle the situation in the future can be addressed.

With collaboration, goals and relationships come into play. Collaboration involves full and open communication—team members must be attentive and open to each other. Collaboration is used when it is important to preserve critical objectives without compromising relationships. It is used when it is important to get to the root of problems that could linger and when there is a complex issue at hand. Be sure to always choose approaches to conflict resolution to best match the situation at hand.

Katzenbach JR, Smith DK. The discipline of teams. Harvard Bus Rev 1993;71(2):111-20.

#### **MUTUAL SUPPORT VIDEO**

#### SAY:

Let's watch the third primary care office demonstrate proper team mutual support.



**DO:** Play the video by clicking the director icon on the slide.



### **DISCUSSION:**

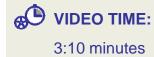
Discuss the video and how things were handled.

### Possible discussion points:

- Was mutual support demonstrated in this video?
- Was this strategy effective? Why was it/was it not effective?
- Did you see any other opportunities for mutual support to be demonstrated in this video?
- Is there another mutual support strategy that might have worked in this scenario?
- Have you encountered similar situations with your team? If so, how did you overcome them?



Slide





Video



### **MUTUAL SUPPORT EXERCISE**



#### SAY:

Take a few minutes and think about the primary care office environment and what types of mutual support problems one could encounter. Can you think of some mutual support behaviors (feedback, advocacy and assertion, two-challenge rule, CUS, DESC script, collaboration) to address and overcome the problem?

### **O** INSTRUCTOR NOTE:

Refer participants to the *Mutual Support Behaviors* handout in the Supplemental Materials. Allow them about 5 minutes to group with two or three other participants and record their thoughts. Then ask if there are volunteers who are willing to share their experiences as well as their suggestions for mutual support behaviors that address the issues.

### FRONT OFFICE SCENARIO



#### SAY:

Now let's look at the following scenario and see how mutual support can be demonstrated in the nonclinical aspects of the primary care team:

#### **READ THE SCENARIO:**

Your clinic has a rule that patients will still be seen if they arrive within a 30-minute window of their appointment. A patient arrives 5 minutes past the window and sincerely apologizes for being late. The secretary tells the patient that he will have to reschedule the appointment and come at a later time. The patient advocate overhears this and pulls the secretary aside. She agrees that the patient should be rescheduled according to the clinic's rules, but she explains to the secretary that this patient lives very far away and relies on friends and family to transport him to doctor's visits and that all efforts should be made to see the patient today. The secretary appreciates this information and the fact that the administrator pulled him aside to tell him. The secretary ensures the patient will be seen today.

As with leadership and situation monitoring, mutual support can also be practiced by everyone within the primary care office. Remember, teamwork is the responsibility of everyone.

#### **MUTUAL SUPPORT TOOLS**

#### SAY:

This is a summary of what this training has covered under mutual support.

Briefly review the headings of barriers, tools and strategies, and outcomes. As you review this slide, point out that there are now additional barriers, additional tools and strategies, and additional outcomes. In summary, mutual support is a core skill that enables teams to function effectively. Supporting team members typically:

- Back up and fill in for each other;
- Are self-correcting;
- Compensate for each other;
- Reallocate functions;
- Distribute and assign work thoughtfully; and
- Regularly provide feedback to each other, both individually and as a team (Sims, et al., 2004).

### **(O)** INSTRUCTOR NOTE:

This is the end of the *Mutual Support* module and is a good place to break. The final module will begin the discussion on *Communication*.

Sims DE, Salas E, Burke CS. Is there a "big five" in teamwork? 19th Annual Meeting of the Society for Industrial and Organizational Psychology, Chicago, IL, 2004.



#### COMMUNICATION



#### SAY:

We will now consider the fourth component of TeamSTEPPS. Communication is "the process by which information is clearly and accurately exchanged between two or more team members in the prescribed manner and with proper terminology and the ability to clarify or acknowledge the receipt of information" (Cannon-Bowers, et al., 1995). There is a tremendous body of evidence to support the efficacy of good communication skills for effective teamwork.

For example, Cannon-Bowers, et al. (1995) found that communication comprises two critical skills: exchanging information and consulting with others. Information exchange is defined as such behaviors as closed-loop communication, which is the initiation of a message by a sender, the receipt and acknowledgment of the message by the receiver, and the verification of the message by the initial sender. Other behaviors include information sharing, procedural talk, and volunteering and requesting information.

Cannon-Bowers JA, Tannenbaum SI, Salas E, et al. Defining competencies and establishing team training requirements. In: Guzzo RA, Salas E, and associates, eds. Team effectiveness and decisionmaking in organizations. San Francisco: Jossey-Bass; 1995. p. 333.

### **COMMUNICATION (CONTINUED)**

#### SAY:

Communication is the lifeline of any team. In health care, it is the lifeline between patients and any member of the team. Historically, medical plans of care were developed and shared with the patients for consent. In the Joint Commission 2008 publication *Guiding Principles for Development of Hospitals of the Future*, health care practitioners are expected to "share complete, unbiased information with patients and families in ways that are affirming and useful. Patients and families are to receive timely, accurate information in order to effectively participate in care and decision-making." For this commitment to be effective, information must flow freely through excellent communication processes that permeate every aspect of an organization.

Some things to consider when communicating include the following:

- The audience—How might your interaction with a receptionist be different from that with a primary care provider?
- The mode of communication—Verbal, nonverbal, written, email
- Standards associated with the specific mode of communication—Nonverbal communication requires verbal clarification to avoid making assumptions that can lead to error. The simple rule is, "When in doubt, check it out, offer information, or ask a question."
- The power of nonverbal communication—The way you make eye contact and the way you hold your body during a conversation are signals that can be picked up by the person with whom you are communicating, although powerful nonverbal communication does not provide an acceptable mode to verify or validate (acknowledge) information. For safety to exist, the message must be verified orally or written.

Here are some examples of nonverbal communication:

- The nonverbal cues a primary care provider gives when looking at an ECG would quickly tell the nurse the severity of the situation and might lead to proactive action.
- The nonverbal cues from the nurse's face might communicate the urgency of the situation and the need for interruption to a doctor who is with a patient's family members.



#### **SBAR**



#### SAY:

SBAR is a framework that team members can use to effectively communicate information about a patient's condition to one another. SBAR stands for **situation**, **background**, **assessment**, **recommendation**, an easy-to-remember mechanism useful for framing any conversation, especially a critical one requiring a clinician's immediate attention and action. SBAR is one technique that can be used to standardize communication, which is essential to developing teamwork and fostering a culture of patient safety. It creates a consistent format for information to be sent and creates an expectation for information to be received.

SBAR originated in the U.S. Navy submarine community to quickly provide critical information to the captain. It provides members of the team with an easy and focused way to set expectations for what will be communicated and how. Standards of communication are essential to developing teamwork and fostering a culture of patient safety.

In phrasing a conversation with another member of the team, you should consider the following:

Situation—What is happening with the patient?

Background—What is the clinical background or context?

Assessment—What do I think the problem is?

**Recommendation**—What would I recommend? What do I need from you?

SBAR provides a vehicle for individuals to speak up and express concern in a concise manner.

Also, remember to introduce yourself. You should not assume that everyone knows who you are.

Finally, I want to point out that SBAR is adaptable and it 's adaptability is strongly encouraged! Try to think of SBAR as a menu. The parts you choose to use and the order in which they are used depend on your team's unique needs. Determine which parts you need and use those when communicating critical information among your team members.

#### **HANDOFF**

#### SAY:

A handoff is the transfer of information (along with authority and responsibility) during transitions in patient care. When a team member is temporarily or permanently relieved of duty, there is a risk that necessary information about the patient might not be communicated. The handoff strategy is designed to enhance information exchange at critical times such as transitions in care. It maintains continuity of care despite changing caregivers and patients.

Handoffs include the transfer of knowledge and information about the degree of uncertainty (uncertainty about diagnoses, etc.), response to treatment, recent changes in conditions and circumstances, and care plan (including contingencies).

In addition, both authority and responsibility are transferred. Lack of clarity about who is responsible for care and for decisionmaking has often been a major contributor to medical error (as identified in root cause analyses of sentinel events and poor outcomes).



### **HANDOFF**



#### SAY:

A proper handoff includes the following components:

**Responsibility**—When handing off, it is your responsibility to know that the person who must accept responsibility is aware of assuming responsibility.

**Accountability**—You are accountable until both parties are aware of the transfer of responsibility.

**Uncertainty**—When uncertainty exists, it is your responsibility to clear up all ambiguity of responsibility before the transfer is completed.

**Verbal communication**—You cannot assume that the person obtaining responsibility will read or understand written or nonverbal communications.

**Acknowledgment**—Until it is acknowledged that the handoff is understood and accepted, you cannot relinquish your responsibility.

**Opportunity**—Handoffs are a good time to review and have a new pair of eyes evaluate the situation for both safety and quality.

#### HANDOFF EXERCISE

#### SAY:

We're now going to work as a group to develop a handoff tool based upon the needs of our own medical office team.

### INSTRUCTOR NOTE:

Refer participants to the handout titled Creating a Handoff Checklist and ask them to form a small group (if their team members are in attendance, with their own teams) and develop a handoff checklist based on the needs of their particular medical office. Ask participants to think about how their team is unique and to keep in mind core components of TeamSTEPPS. Allow about 10 minutes for this activity and then sample responses from the group.





#### **CHECK-BACK**



#### SAY:

A check-back is a closed-loop communication strategy used to verify and validate information exchanged. The strategy involves the sender initiating a message, the receiver accepting the message and confirming what was communicated, and the sender verifying that the message was received. This can be described as similar to placing an order at a fast food counter or drivethrough window—the sender of the information places the order, the receiver accepts the message and repeats the order to ensure that he/she has the correct information, and the sender verifies that the message was received and confirms that the order is accurate.

Typically, when a team member calls out information, he/she anticipates a response on any order that must be checked back. For example, if a team member was asked by a primary care provider to administer the influenza vaccine to Mrs. Greene in room 6, upon hearing this, the team member should check back to the primary care provider. The team member should confirm by saying, "So, you want me to give Mrs. Greene the influenza vaccine in room 6? I will prepare the vaccine. Please provide the follow-on order."

#### **COMMUNICATION VIDEO**

#### SAY:

Let's watch the fourth primary care office demonstrate proper team communication.



**DO:** Play the video by clicking the director icon on the slide.



### **DISCUSSION:**

Discuss the video and what they did right this time . Ask participants if anything else could have been done to improve the situation.

#### Possible discussion points:

- Was proper communication demonstrated in this video?
- Was this strategy effective? Why was it/was it not effective?
- Did you see any other opportunities for better communication in this video?
- Have you encountered similar situations with your team? If so, how did you overcome them?







Video



#### **COMMUNICATION EXERCISE**



#### SAY:

We're now going to take a few minutes and think about our team's communication. What are some areas for improvement? How are staff involved? How are patients and families involved? If you had a magic wand, what strategies would you use to address the communication breakdowns in your team?

### **O** INSTRUCTOR NOTE:

Allow them about 5 minutes to group with two or three other participants and share their experiences. Then ask if there are volunteers who are willing to share their experiences as well as their suggestion for a strategy that can be used to address the issue.

#### FRONT OFFICE SCENARIO



#### SAY:

Now let's look at the following scenario and see how communication can be demonstrated in the nonclinical aspects of the primary care team.

#### **READ THE SCENARIO:**

For some unknown reason, the electronic health records system was not functioning and the staff had to transition to writing paper notes. A patient had an appointment for followup of labs and x rays. Since there was no way to access the diagnostic data, the provider asked the secretary to call both the laboratory and the radiology service to get the results via telephone. The secretary called and explained the situation, the background, and the assessment, and requested the necessary information. This method of communication expedited the transfer of information from the radiology technician to the secretary. The provider was then able to see the patient on time and discuss the lab and x ray results.

Did anyone pick up on the use of SBAR in this scenario? The administrative assistant calls and explains the situation, the background, and the assessment, and requests the necessary information.

As with all the other TeamSTEPPS concepts, good communication applies to everyone within the primary care office. Remember, teamwork is the responsibility of everyone.

#### PATIENT- AND FAMILY-CENTERED CARE



#### SAY:

The last thing we will cover in this training session is the importance of including the patient and the patient's family in the health care process. Keeping the patient and family engaged in the process is beneficial for everyone involved. It ensures that information is properly exchanged and that all parties stay informed of decisions that affect them. This is consistent with all of the TeamSTEPPS skills that we have just learned.

As patients become more empowered, they become more proactive in the decisions that affect their health. As they do this, health care providers are able to deliver more comprehensive, personalized, and continuous care.

To ensure that patients are always involved and engaged with their own care, teams should:

- Hear the patient's stories, be open and honest with them, and take action with them.
- Respect the patient and family as the central hub of the care team.
- Make sure patients share fully in decisionmaking.
- Speak to patients in a way they can understand and enable them to feel empowered to be in control of their care.

#### **EQUIPPING THE PATIENT**

#### SAY:

Providing patient-centered care is about empowering and equipping the patient with the right tools to stay properly engaged.

Improving health care quality is a team effort. Patients can improve their care and the care of their loved ones by taking an active role in the process. Encourage them to ask questions, understand their condition, and evaluate their options.

The AHRQ Web site "Questions Are the Answer" is a great resource for patients and families to find information about what questions to ask their providers, found at the Web address below.

To the right are some examples of types of questions patients should be asking their care providers.



### **PATIENT-CENTERED SCENARIO**



#### SAY:

We're now going to look at a possible scenario from a primary care office and see how the idea of patient-centered care applies here. Please read the scenario on the screen as I read it aloud.

Janet brought her 6-year-old son Billy to Dr. Lee's office with sore throat and fever. After a quick strep test, Dr. Lee diagnosed Billy as having strep throat. Dr. Lee ordered amoxicillin 250 mg 3 times a day for 10 days. Janet said, "I really hate to give Billy medications; can we wait to see if it will go away by itself?" Dr. Lee said, "Janet, strep throat is serious and can lead to rheumatic fever, which can cause inflammation of his heart and permanent heart murmur – he needs to take this medicine." Janet looked very alarmed but said nothing else and simply thanked Dr. Lee as he walked out. Jill, the medical assistant who remained in the room with Janet and Billy, asked Janet if she had any questions. Janet said she couldn't think of any. Jill knew the importance of working with the patient and family to involve them in the plan of care. She encouraged Janet to discuss any concerns and always ask questions.

What are some questions Jill can help Janet think about?

## **O** INSTRUCTOR NOTE:

Allow the participants time to think of some potential questions that Jill might provide to the patient's mom, Janet. If participants have a difficult time coming up with example questions, provide them with a few of the ones listed below:

"Do you know any of the side effects of Cephalexin?"

"Do you know what to do if Billy presents any of the side effects?"

"You look concerned – can you tell me what you understood Dr. Lee to say?"

After this exercise is finished, allow participants to provide other ideas that they may have that would involve and engage patients and their families more fully in their own care.

### **BARRIERS - TOOLS - OUTCOMES**

#### SAY:

This is a summary of what this training has covered for all four skill areas—leadership, situation monitoring, mutual support, and communication. As you can see, there are now additional barriers, additional tools and strategies, and additional outcomes because this represents all four skill areas.



### HIGH-FUNCTIONING PRIMARY CARE OFFICE-**BASED TEAM**



#### SAY:

Let's watch our four primary care office teams demonstrate all four of the core teamwork skills discussed during this training.



**DO:** Play the video by clicking the director icon on the slide.

### **INSTRUCTOR NOTE:**

After video is finished, proceed to next slide to wrap up the training with discussion.



14:16 minutes



#### **MATERIALS:**

Video



#### **BRINGING IT ALL TOGETHER**

#### SAY:

Now that we have covered the information in this training, let's try to identify the successes and failures of the team in our final video. Specifically, what were their successes and what were their failures?



## INSTRUCTOR NOTE:

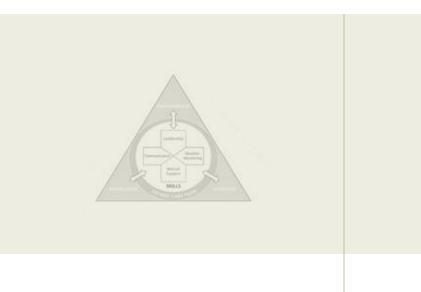
Facilitate discussion among the participants about the successes and failures of the team in the final video.

- How were some of the TeamSTEPPS strategies applied?
- Were there other strategies that could have been applied that were not?
- Can you see your team engaging in some of these strategies?
- Which team work strategies that we covered do you think will be most effective with your team?

#### SAY:

Now that we have explored the four core skills of TeamSTEPPS—leadership, situation monitoring, mutual support, and communication—what will you do with what you have learned? Can each of us make a list of things we want to address with our own medical office team and prioritize the items on the list to determine what we would like our teams to address first, second, etc.?

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JoAnn Phillips Wood, M.D., M.S.Ed., FAAP, FACP John Hickner, M.D., M.Sc.

#### **Technical Expert Panel**

James B. Battles, Ph.D., AHRQ
Penny Casebolt RN, B.S.N., University of Arkansas for Medical Sciences
Steven A. Garfinkel, Ph.D., AIR
Janice L. Genevro, Ph.D., AHRQ
John Hickner, M.D., Cleveland Clinic
Heidi B. King, M.S., DoD/TMA (HA)
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